If you have more than one claim, you must copy this form to report additional claims

PLEASE READ THIS FORM CAREFULLY AND NOTE THAT YOU ARE MAKING THE FOLLOWING STATEMENTS UNDER OATH:

PROOF OF CLAIM

Against

Tennessee Trucking Association Self Insurance Group Trust (TTA-SIGT) in Liquidation

BEFORE ME, the undersigned Notary Public, appeared the person whose name is subscribed hereto, who states under oath that, Tennessee Trucking Association Self Insurance Group Trust, in Liquidation, after deducting all offsets and counterclaims is indebted to him/her as follows:

Claimant Name _____ Claim No: _____
(Party who is executing this claim and to whom payment should be made) (If Known)

Claimant Address _____
(Street or Box Number) (City) (State) (Zip Code)

Work Phone ( ) _____-_____ State of residence at the time the claim(s) occurred: _____
Home Phone ( ) _____-_____ Federal Tax ID No.: _____

Insured _____ Policy No.: _____

Address _____
(Street or Box Number) (City) (State) (Zip Code)

_____
(State particulars of your claim, including consideration given for the claim, and the payments made on your claim, if any.)
(Attach additional sheets of paper, if necessary.)

_____
(Identify the security for your claim and its value and any right to priority of payment.)

Have you received any amounts or benefits from TTA-SIGT since February 6, 2004? _____ If yes, the Liquidator requires confirmation that you desire those benefits and payments to be included as part of your proof of claim. **Please check here _____,** to confirm their inclusion in the Proof of Claim. **FAILURE TO CONFIRM THROUGH CHECKING THIS ITEM WILL ENTITLE THE LIQUIDATOR OF TTA-SIGT TO RECOVER THESE AMOUNTS FROM YOU.**

Describe and list any amounts or benefits received to date:
_____

Attorney's Name: _____

Attorney's Address: _____
(Street or Box Number) (City) (State) (Zip Code)

Date of Loss: _____ Time Lost from Job: _____ Date Released from Medical Care: _____ Temporary Partial Disability Claimed $ _____ Temporary Total Disability Claimed $ _____
Future Medicals Claimed: $_____ Permanent Partial Disability Claimed: $_____ Permanent Total Disability Claimed: $_____ Death Benefit Claimed:$ _____Other: $_____ **Total Amount Claimed Due: $_____**
If an amount is listed as other, state basis of your claim. _____ **(This must be completed)**

I hereby certify that the above account is TRUE and CORRECT and no part of the amount claimed due has been paid by Tennessee Trucking Association Self Insurance Group Trust or the Liquidator. There is no setoff, counterclaim or defense to this claim. If your claim is based on a written document, please attach a copy of the document that is the basis of your claim.

State of _____ County of _____

Sworn to or affirmed before me this _____ day of _____ 2004.

My Commission Expires: _____ _____
Notary

_____
(Individual Claimant's Signature)

If claimant is a Corporation, Partnership or
Limited Liability Company, state your Title or Position

Name of Organization: _____

By: _____

Title: _____

THE CHANCERY COURT OF DAVIDSON COUNTY HAS ESTABLISHED A NEW DEADLINE THAT ALL FULLY COMPLETED PROOFS OF CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR ON OR BEFORE DECEMBER 31, 2004 AT 4:30 P.M. CST AT THE FOLLOWING ADDRESS: Cannon Cochran Management Services, Inc., 402 BNA Drive, Building 100, Suite 106, Nashville, TN 37217.